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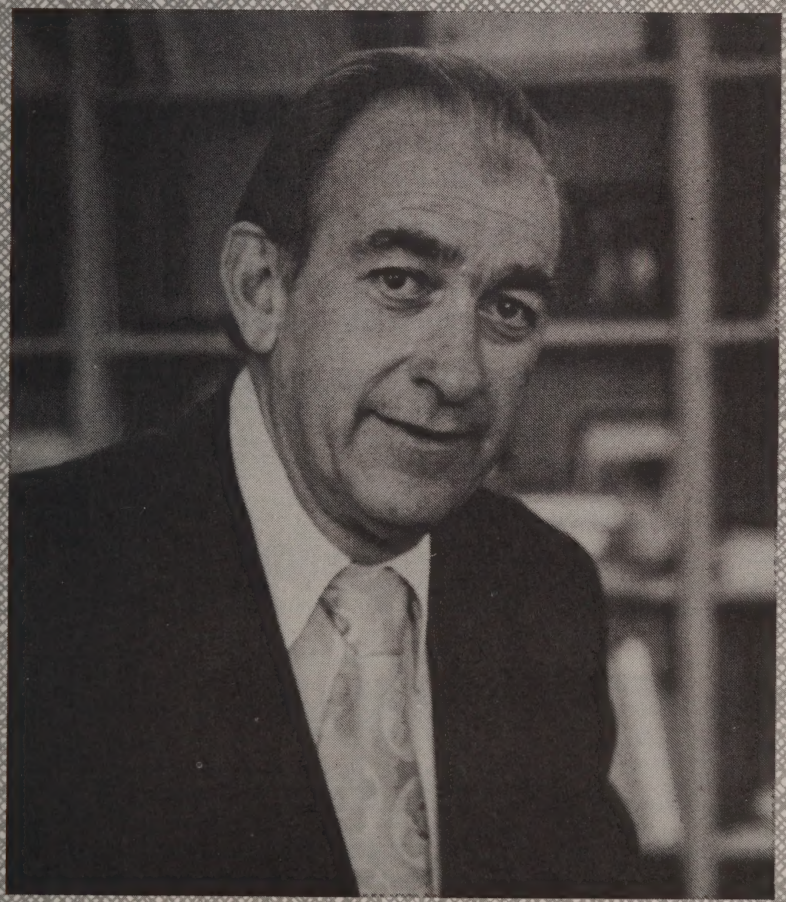
1980



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# *Does The Hampden District Medical Society Have Its Feet In The Mud?*

Do you think our stodgy old society needs new ideas and new direction? If you do, join the appropriate committee and give us your ideas and help us to convert them into action.

Contact Vivian Purdy in the office or call one of these listed chairmen of the committees and indicate your interest. □

**JAMES J. SIRAGUSA, JR., M.D.**
**President Elect**

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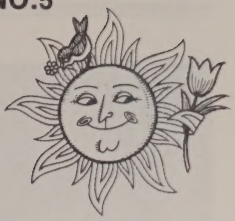

# Contents

**Committee Chairmen 1980-1981** ..... 4

**An Appeal For Unity** ..... 6
Franco Navazio, M.D. President

**In Memoriam Aldo J. Leani, M.D.** ..... 9

**President Elect's Page** ..... 11
James J. Siragusa, Jr., M.D.

**CARE MEDICO in Peru** ..... 13
Garry deN. Hough, III, M.D.

**Executive Committee** ..... 15

**Executive Committee** ..... 18

**Recent Trends in Child Neurology** ..... 21
Anthony H. Jackson, M.D.

**Child Abuse** ..... 24
Edward N. Bailey, M.D.

**The Communication Gap** ..... 27

**The Four Seasons** ..... 28
Setrag A. Zacarian

**Letter to the Editor** ..... 29
Joseph W. Kresock, M.D.

**List of Advertisers** ..... 30

THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
ALL COMMUNICATIONS SHOULD BE ADDRESSED TO VIVIAN M. PURDY, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109; TELEPHONE: 736-0661.
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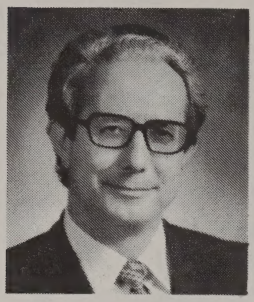

# PRESIDENT'S PAGE

## *An Appeal For Unity*

A newcomer to the American medical scene might conclude from the prevalence of press reports that medical care in this country is in an advance state of rot. This despite the fact that public opinion polls indicate that large majority of the American people consider themselves well looked after by the medical profession. The polls continue the rank medicine in high prestige and trustworthiness and, at least in middle-class ranks, people speak with singular reverence about their personal physician. Why then does the press persist in presenting dour reports on the state of American medicine? The wave of criticism being indeed fundamental and rather than being confined to isolated atrocities, directs serious charges at the overall organization of health care, its economics, ethical standards and efficacy.

Let us find the etiology of the phenomenon. In Washington, for example, the wire service provide daily their customers with a schedule of forthcoming hearings, press conferences and official proceedings. Repertorial troops are dispatched to attend what seems to be the most interesting of these proceedings. As in recent years federal interst in health-care policy has spawned, we have as a consequence, a lot of analyses and reports on the economics and administration of health care. Of course the problems outlined in these hearings seem sound and do cry for attention. The press (and the news) do little more than passing along the word from officialdom. The Department of Health and Welfare is at present obsessed with cost containment and the inequities, inefficiencies and dangers of modern medical practice. So money is put into studies designed to substantiate its preconceptions. Of course the resources are generous and the people performing the studies are capable and as there is indeed a lot wrong with American medicine the results are inevitable.

If someone financed a study to catalogue happy-ending stories of medical care, including tales of night calls in nasty weather, unremunerated service and recalls from the near dead, a smashing report could be produced. But the present-day politics calls for concentrating on what's wrong and the press repeats what it hears from proper sources and the sources are saying unkind things about American medicine.

Truly in and outside Washington, politicians have found in doctors the scapegoats for a number of national misfortunes and it is now, politically advantageous to invoke iron-clad reforms. Unfortunately even those representatives who when talking to us lavish upon us showers of positive attributes, when faced with a vote..."zac" too often raise their hand with the other side.

Union leaders focus on or better against doctors much of their pressures. In their demands free medical care is of paramount importance and almost constantly in their allocations. England, this paradise of free medical miracles, is brought as an example.

Poor people dislike doctors! They feel a class difference helped by a constant propaganda which displays ad nauseam the astronomical (sic!!) incomes of physicians. It is almost funny the fact that very few people happen to know the average income say of lawyers, architects, actuarial experts, naval engineers or airline pilots while instead the physicians income per area, per region or per specialty appears on our medial with suspicious recurrence.

Rich people don't like doctors either. They look at us as some kind of "nouveau riche", sort of ladder climbers and while accepting as part of their group few fashionable names of international reputation remain instead very much indifferent to our destiny.

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A sad note is that doctors don't like doctors and here is where my appeal goes at the end of my tenure as President of our County Medical Society. Conflicts of personality, differences in technical skills, threats against monopolistic interests place too often physicians versus physicians. To many medical academicians confuse excellence in teaching with excellence in the provision of care, too many senior partners consider the collapse of a professional partnership as a cause for total break in relationship with the younger colleague.

Let me remind all of you that more and more we are being called upon to account for our diagnostic and treatment regimens as well as to be aware of the cost of the things that we order.

We are still in time to participate in the process of quality-directed health-care activities with leadership and creativity. We can provide public officials and informed laymen with constructive plans and data of superior quality.

With your support the Hampden District Medical Society may become a stronger speaker versus every criticism. Every physician in whatever specialty and whatever position should become part of our team. We should be more and more the voice of medicine in our area talking with authority to the executive agencies to the local, state, and federal government. We will help foster the development of health programs while still maintaining the ongoing review of pending legislations. And be this our pledge for the oncoming year. □

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# *In Memoriam*

## ALDO J. LEANI, M.D., 1910-1980

Dr. Aldo J. Leani died suddenly in his home on Saturday, April 12, 1980 at age 70.

He was born in Barre, Vermont on February 7, 1910 and was educated in the public schools of Barre before graduating from the University of Vermont where he also received his Doctorate of Medicine in 1934.

He interned at the Springfield Hospital from 1934 to 1935 and then entered general practice in Barre Vermont. He was Captain in the Army of the United States during World War II and following his interruption of his practice became a resident in Orthopedic Surgery at Kings County Hospital in Brooklyn, New York in 1944 and 1945. He had a senior residency in Orthopedic Surgery at the Rhode Island Hospital in 1946 and in 1947 he opened his practice or Orthopedic Surgery in Springfield.

He was on the staff as Senior attending surgeon in Orthopedics at Mercy Hospital and Providence Hospital and on the consulting staffs of the Noble Hospital, Westfield and the hospitals in Ware, Palmer and Stafford Springs, Connecticut.

Dr. Leani was a member of this society, the Mass. Medical Society, the American Medical Association, the American College of Surgeons, the International College of Surgeons, the American Fracture Association, the American Academy of Orthopedics and was a Diplomate of the American Board of Orthopedic Surgery.

He was married to Marguerite (Donahue) Leani in 1940 and she, his mother, Mrs. Lucia Leani and several nieces and nephews survive him.

At times Aldo appeared to be as rough and hard as the granite his father, a stone cutter, removed from the Barre hills. However, no docotor was ever more devoted, more kind or more charitable than he to his patients, to his wife and to relatives and friends. He was also a great philanthropist and gave thousands of dollars to the University of Vermont. He financed the educations of his nieces and nephews.

He was obsessed with truthfulness and wrote and spoke with ardent veracity. He was one of the most sincere men that I have ever known. He was analytical and self critical. Above all he was an excellent doctor. □

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# President Elect's Page

Here I am. I'm a new boy. I started a year ago as President Elect with no qualifications except that, as father of eight, I have developed the knack of nagging and heckling other people into accomplishing great things. That is precisely what I intend to do for the coming year. I have spent the last year following Franco Navazio and Vivian Purdy around town, state and country learning about our organization, and they have given me an education.

I have learned that the Society is accomplishing a lot more than I ever imagined. We have an active committee network made up of devoted men who are working diligently at their particular jobs. I expect that most of you are not aware of the work that is being done. One of the reasons is that the society has been loathe to blow its own horn. Keep reading your Hippocrat and as the year goes on, expect us to tell you what a good job we are doing.

I have learned that the Auxiliary is a great power source that has been very supportive in many areas. I intend to use and abuse the Auxiliary. The degree of their enthusiasm can well be influenced by our willingness to involve them in policy and decision-making. If you are in a committee and find a pretty lady sitting beside you at your next meeting don't be surprised. I have received the permission of the Executive Committee to include key Auxilians on our committees. At home most of us are led around by the nose by an Auxilian. Why not let them go public.?

And I have also learned that our greatest source of power and direction is our Executive Secretary, Vivian Purdy who, I think Franco would agree, is really the President of the Society. Guys like Franco and I come and go and Vivian goes on and on and on. We want it to stay that way.

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What do I intend to do with all this power? I have in my mind a rather undefined theme. That theme calls for directing the energies of the Society in toward public involvement. I see a need for us to cooperate with, negotiate with, and, if necessary, do battle with the public, (i.e. the consumers, the health planners, the legislators), in an effort to effictively address the problems in our health system as they see them. That last phrase, "as they see them," is vital to our approach. The major problem as they see them, are distribution and cost. We all recognize these problems, but we have failed to do anything about them. If we don't get our act together and visibly do something they will continue in their efforts to do it without our help, with the result that they will end up telling us how and where to practice medicine. If this happens it will be our fault.

In our eyes there are more urgent problems that organized medicine must address in Massachusetts: Medicaid fees, Blue Shield policies, Ted Kennedy, etc. We have been addressing these problems with great vigor and negligible results for years. Why? Because nobody listens to us. Because we have lost our credibility. They think we are vultures. They are convinced that we are not the least bit interested in saving the patient a buck.

By self-education in health care costs, by appropriate public realtions efforts and by involvement in local health planning we can educate and convince the public that we are truly interested in trying to solve the problems of health care as they see them. We will regain credibility. Then, when we go to the consumers and the legislators with our chief complaints, as we see them, they will listen to us.

I am sincerely grateful to you all for giving me the honor of being your President for the coming year. □

**JAMES J. SIRAGUSA, JR., M.D.**

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# CARE MEDICO in Peru

As many Hampden Hippocrat readers know, I am a strong supporter of CARE-MEDICO. MEDICO is the medical arm of CARE (Committee for American Relief Everywhere, Inc.). Just as CARE has graduated from sending supplies to sending teachers (in agriculture, water supply, road building, school construction, etc.) so MEDICO has graduated from medical service to visiting professors serving a month at a time, for integrated postgraduate education. Many organizations support medical service teams overseas. Few of these demand the local support and cooperation which is the hallmark of CARE's contribution. Five years ago I was the 72nd orthopedic surgeon to teach in the resident training program in Jakarta, Indonesia. In April, 1980, I was the 6th "visiting volunteer specialist" to serve in Peru. My time was divided between Lima and the city of Ica, 200 miles to the south. Teaching was conducted in Spanish with the aid of bilingual surgeons. I gave lectures, did surgery, held clinics and had a wonderful time.

Orthopedic surgery in Lima varies from superb to atrocious. I learned a lot, taught a little and worked with a number of competent orthopedic surgeons. 'In Ica, three self-trained orthopedic surgeons service a city of 180,000. The standard of care is higher than in Indonesia, but there are shortages of surgical linen, suture material and orthopedic hardware. The greatest shortage however, is in educational opportunity. With a salary of $200.00 a month, augmented by a minor amount of private practice, physicians cannot afford to travel to out-of-town meetings and seminars. Textbooks take two or three years to get translated into Spanish and then cost four times as much as they do in the United States. The drug detail man is still a major source of medical information. I have never seen doctors as hungry for information. A forty-five minute lecture to the attending physicians and house staff would be followed by an hour of questions.

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As in the United States, trauma is a major part of orthopedic practice. I also treated tuberculosis, poliomyelitis residuals and hematogenous osteomyelitis. My major teaching effort centered around the prevention and care of surgical infections. Ica is no tourist paradise, but it is strong on friendship and hospitality.

For those of you who enjoy new places, new people and new ideas, a tour with MEDICO provides an unparalleled opportunity. For those of you who enjoy teaching and service, a tour with MEDICO provides an effective opportunity and a committed audience. For those of you who need a better comprehension of the advantages of being a physician in the United States, a tour with MEDICO provides a valuable perspective. For those of you who prefer to stay home, a donation to CARE provides $6.00 of overseas program for each $1.00 of private donation. Where can you get a bargain like that?

I returned from Peru filled with pride, enthusiasm and wonder. I have further information for those who would like to acquire these same emotions. □

**GARRY deN HOUGH, III, M.D.**

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# EXECUTIVE COMMITTEE March 18, 1980

The Executive Committee of the Hampden District Medical Society met on Tuesday, March 18, 1980 in the Conference Room.

Present were Drs. Navazio, Walthall, Remsberg, Bloom, Siragusa, Dasco, Stoddard, Rich, Bagamary and Mrs. Purdy. Dr. Morgan, dentist was present also.

Dr. Howard Simpson, guest was welcomed by Dr. Navazio. Dr. Simpson is the Hampden representative on the Bicentennial Committee of the Massachusetts Medical Society. Dr. Simpson gave an up to date report on the actions and plans of the committee for celebrating the 200th anniversary in 1981. Meetings and functions will begin in May of 1981 with the Annual Oration on May 20th. November 1, 1981 will be World Medicine Day when Nobel laureates will be invited. The Scientific Session of the American Medical Asociation will be in Boston. Several other celebrations will take place such as a special concert at Tanglewood, a special issue of the New England Journal of Medicine, exhibits in various parts of the state, etc. Hampden has been asked to have an exhibit. Plans for this will be made later this year.

Dr. Siragusa was called to see a patient.

The minutes of the February Executive meeting were approved as written and amended.

CORRESPONDENCE

A letter concerned with a Retired Physicians Placement service was read. This has been given to the business manager of the Hampden Hippocrat for placing an ad into that publication.

# FOR THE HANDICAPPED

Mayor DiMauro of Springfield has officially announced the opening of a temporary office for Handicapped Affairs at 1176 Main Street. The goal of this office is to provide information and referral to the handicapped population of Springfield.

If you have patients that need information of meetings, educational, recreational or social events connected with being handicapped have them contact Ms. Betsy Wolf at 781-6900. □

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The Advertising Club of Western Massachusetts want to honor a person with the William Pynchon Awards and asked for names of worthy physicians. Three names were suggested and will be sent into the club for consideration.

A letter from Dr. Navazio sent to Dr. Frechette about the local HSA was read as informational.

The American Medical Association is seeking qualified physicians who are graduates of foreign medical schools to serve on Councils of the American Medical Association. Dr. Navazio's name will be sent in as a suggestion.

Information on an adolescent health program sent in from Dr. Munier was considered as information.

A letter from the Massachusetts Chapter of the American College of Emergency Physicians was read and received as informational. This information will be sent to Drs. Keroack and DiGiacomo.

A letter to Massachusetts Medical Society written by a member on his dues bill was read along with the answer from Dr. Rodkey, President of the Massachusetts Medical Society. This referred to the Medical Examiner problem in the state.

Dr. Schwendenmann made a statement at a public hearing about the clinic run by the Wing Memorial Hospital in Wilbraham. This was informational to the committee.

A letter to Dr. Bloom which was a result of the printed letter in the last issue of the Hampden Hippocrat was read as informational to the committee.

Dr. Sammons wrote to Dr. Stoddard thanking him for his letter and extended best wishes for the continued efforts of the Hampden District Medical Society.

OLD BUSINESS

Deprivation of membership for some delinquent members was discussed by the committee. Dr. Remsberg has spoken with all these previously. The By-Laws must be followed about delinquency.

The Academy of Medicine has asked that their educational meetings be held on the same dates as the Hampden District Medical Society district meetings during the coming year. After discussion it ws decided to vote on this at the April meeting of the Executive committee.

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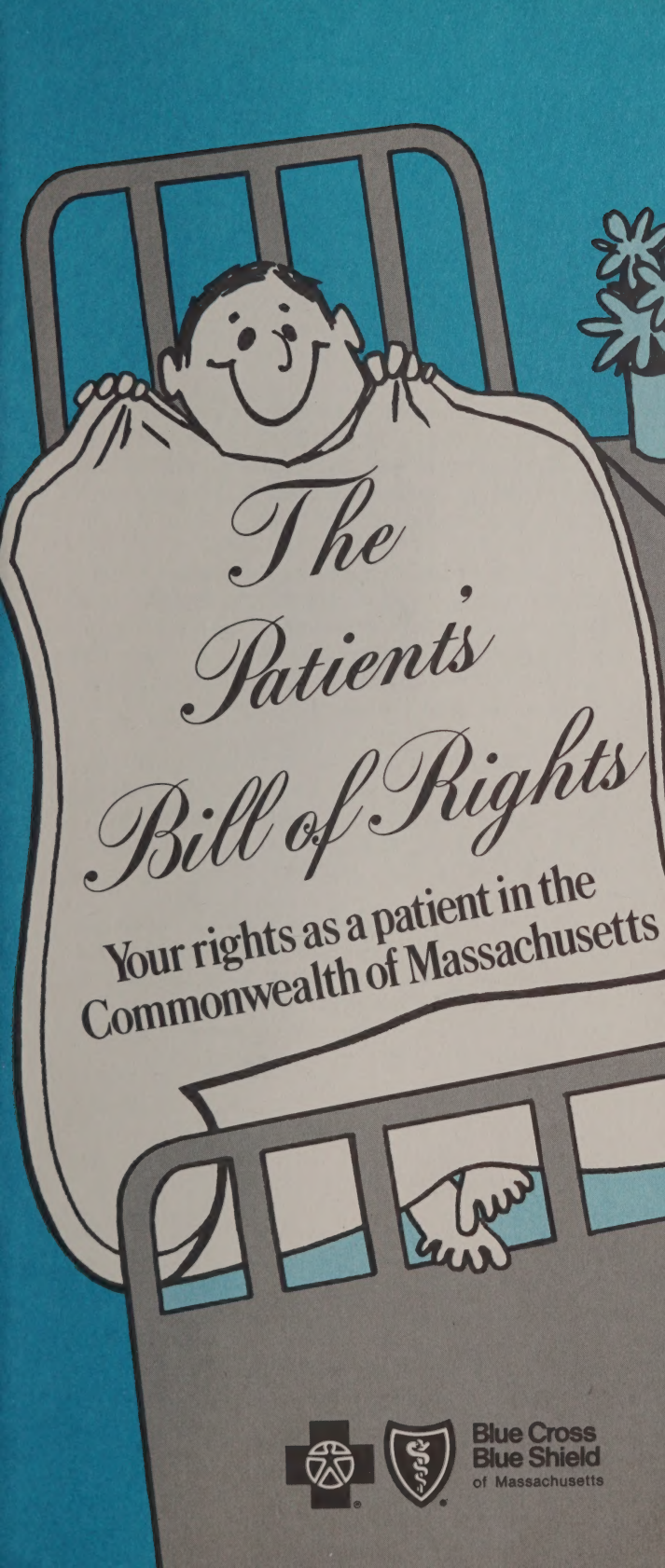


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On May 23, 1979, Governor Edward King signed into law Chapter 214 of the Acts of 1979, commonly known as the Patient's Bill of Rights. It became effective on August 21, 1979, and is summarized here.

Patients or residents have always been guaranteed certain rights by law. But for the first time, this act codified and clarified their rights, and in some cases extended them. It states the responsibilities of both institutions and physicians working in them.

The law affects patients or residents in hospitals, clinics, rest and convalescent homes, nursing homes, charitable homes for the aged, unwed mothers institutions, state hospitals and other health care facilities.

The law requires that patients or residents receive rights in writing when admitted. Also, members of health maintenance organizations shall receive their rights both upon enrolling and also when admitted for treatment. Rights must also be conspicuously posted.

## YOUR RIGHT TO TREATMENT

As a patient or resident of a facility, you have the right to:

- LIFE-SAVING MEDICAL TREATMENT in an emergency without harmful delay to discuss payment and without discrimination on account of economic status or source of payment.

- INFORMED CONSENT, or being told about the nature of your problem and the risks and benefits of the proposed treatment, and you must give your consent to the treatment. In the case of any form of breast cancer, you have the right to complete information on all alternative treatments that are medically viable.

- FREEDOM OF CHOICE in your selection of a doctor or facility, except in an emergency, to the extent possible and if the doctor or facility is able to accommodate you.

## YOUR RIGHT TO PRIVACY

You have the right to:

- CONFIDENTIALITY of records. (Your records are still open to insurers if you claim reimbursement for the services and treatment. Records are also open to peer review and utilization review proceedings.)

- PRIVACY during medical treatment and care.

## YOUR RIGHT TO YOUR RECORDS AND BILLS

You have the right to:

- INSPECT your medical records, or to receive a copy of your records for a reasonable fee.

- RECEIVE an itemized bill from your doctor and from the facility showing payments made by third party payors.

- RECEIVE from the facility a copy of bills submitted to insurers or other third party payors for your care.

- INFORMATION about financial assistance or free care from your facility.

## YOUR RIGHT TO INFORMATION ABOUT THE FACILITY

You have the right to:

- AN EXPLANATION of any relationship between the facility and any other health care facility or educational institution, if this relates to your care or treatment.
- A COPY OF ANY RULES which apply to your conduct as a patient or resident.

## YOUR RIGHT TO INFORMATION ABOUT THE DOCTOR

You have the right to:

- THE NAME and specialty, if any, of the doctor, or any other person responsible for your care or for coordinating your care.
- AN EXPLANATION of any relationship between the doctor and any other health care facility or educational institution, if this relates to your care or treatment.

## YOUR RIGHTS IN RESEARCH AND TEACHING

You have the right to:

- REFUSE to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.
- REFUSE to be examined, observed or treated by students or any other staff without jeopardizing your access to care.

## YOUR RIGHT TO ENFORCEMENT

You have the right to:

- BRING AN ACTION or complaint by a special procedure specified in the law for violation of your rights.

REMEMBER that the above is a **summary** of the new law. The **actual** law, in its entirety, is reprinted on the next five pages:

S 1757

*Chapter 214.*

THE COMMONWEALTH OF MASSACHUSETTS

*In the Year One Thousand Nine Hundred and Seventy-nine*

# AN ACT PROVIDING CERTAIN RIGHTS TO PATIENTS AND RESIDENTS IN HOSPITALS, CLINICS AND CERTAIN OTHER FACILITIES.

**Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:**

Chapter 111 of the General Laws is hereby amended by inserting after section 70D the following section:—

**Section 70E.** As used in this section, ''Facility'' shall mean any hospital, institution for the care of unwed mothers, clinic, infirmary maintained in a town, convalescent or nursing home, rest home, or charitable home for the aged, licensed or subject to licensing by the department; any state hospital operated by the department; any ''Facility'' as defined in section three of chapter one hundred and eleven B; any private, county or municipal facility, department or ward which is licensed or subject to licensing by the department of mental health pursuant to section twenty-nine of chapter nineteen; any ''Facility'' as defined in section thirty-eight of chapter one hundred and twenty-three; the Soldiers' Home in Holyoke, and the Soldiers' Home in Massachusetts.

The rights established under this section shall apply to every patient or resident in said facility. Every patient or resident shall receive written notice of the rights established herein upon admittance into such facility, except that if the patient is a member of a health maintenance organization and the facility is owned by or controlled by such organization, such notice shall be provided at the time of enrollment in such organization, and also upon admittance to said facility. In addition, such rights shall be conspicuously posted in said facility.

Every such patient or resident of said facility shall have, in addition to any other rights provided by law, the right to freedom of choice in his selection of a facility, or a physician or health service mode, except in the case of emergency medical treatment or as otherwise provided for by contract, or except in the case of a patient or resident of a facility named in section fourteen A of chapter nineteen; provided, however, that the physician, facility, or health service mode is able to accommodate the patient exercising such right of choice.

Every such patient or resident of said facility in which billing for service is applicable to such patient or resident, upon reasonable request, shall receive from a person designated by the facility an itemized bill reflecting laboratory charges, pharmaceutical charges, and third party credits and shall be allowed to examine an explanation of said bill regardless of the source of payment. This information shall also be made available to the patient's attending physician.

Every patient or resident of a facility shall have the right:

**(a)** upon request, to obtain from the facility in charge of his care the name and specialty, if any, of the physician or other person responsible for his care or the coordination of his care;

**(b)** to confidentiality of all records and communications to the extent provided by law;

**(c)** to have all reasonable requests responded to promptly and adequately within the capacity of the facility;

**(d)** upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution insofar as said relationship relates to his care or treatment;

**(e)** to obtain from a person designated by the facility a copy of any rules or regulations of the facility which apply to his conduct as a patient or resident;

**(f)** upon request, to receive from a person designated by the facility any information which the facility has available relative to financial assistance and free health care;

**(g)** upon request, to inspect his medical records and to receive a copy thereof in accordance with section seventy, and the fee for said copy shall be determined by the rate of copying expenses;

**(h)** to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care and attention;

**(i)** to refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;

**(j)** to privacy during medical treatment or other rendering of care within the capacity of the facility;

**(k)** to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the

source of payment unless such delay can be imposed without material risk to his health, and this right shall also extend to those persons not already patients or residents of a facility if said facility has a certified emergency care unit;

**(l)** to informed consent to the extent provided by law; and

**(m)** upon request to receive a copy of the bill or other statement of charges submitted to any third party by the facility for the care of the patient or resident.

Every patient or resident of a facility shall be provided by the physician in the facility the right:

**(a)** to informed consent to the extent provided by law;

**(b)** to privacy during medical treatment or other rendering of care within the capacity of the facility;

**(c)** to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological or other medical care and attention;

**(d)** to refuse to serve as a research subject, and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;

**(e)** to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of source of payment unless such delay can be imposed without material risk to his health;

**(f)** upon request, to obtain an explanation as to the relationship, if any, of the physician to any other health care facility or educational institutions insofar as said relationship relates to his care or treatment,

and such explanation shall include said physician's ownership or financial interest, if any, in the facility or other health care facilities insofar as said ownership relates to the care or treatment of said patient or resident;

**(g)** upon request to receive an itemized bill including third party reimbursements paid toward said bill, regardless of the sources of payment; and

**(h)** in the case of a patient suffering from any form of breast cancer, to complete information on all alternative treatments which are medically viable.

Any person whose rights under this section are violated may bring, in addition to any other action allowed by law or regulation, a civil action under sections sixty B to sixty E, inclusive, of chapter two hundred and thirty-one.

No provision of this section relating to confidentiality of records shall be construed to prevent any third party reimburser from inspecting and copying, in the ordinary course of determining eligibility for or entitlement to benefits, any and all records relating to diagnosis, treatment, or other services provided to any person, including a minor or incompetent, for which coverage, benefit or reimbursement is claimed, so long as the policy or certificate under which the claim is made provides that such access to such records is permitted. No provision of this section relating to confidentiality of records shall be construed to prevent access to any such records in connection with any peer review or utilization review procedures applied and implemented in good faith.

No provision herein shall apply to any institution operated or listed and certified by The First Church of Christ, Scientist, in Boston, or patients whose religious beliefs limit the forms and qualities of treatment to which they may submit.

No provision herein shall be construed as limiting any other right or remedies previously existing at law.

**—END OF LAW—**

This booklet has outlined your legal rights as a patient of a hospital or as a resident of many types of health care facilities.

You should remember that you have **responsibilities** as well as rights. One of those responsibilities is to attempt to maintain your health by refraining from unhealthy habits and lifestyles. The Blue Cross and Blue Shield **Health thyself®** program was started to help Massachusetts residents learn to stay healthy by quitting smoking, getting more exercise, improving diet and eating and drinking moderately.

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[This publication was printed in November, 1979, and explains the provisions of the Patients' Bill of Rights law as it was in effect at that time.]

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070140

NEW BUSINESS

Representative McKenna had called Mrs. Purdy asking if the Hampden District Medical Society would have an opinion of the possible closing of the Western Massachusetts Hospital in Westfield. The Committee discussed this but decided to not comment on it at this time.

The city of Springfield is to have a Health Fair for the elderly on May 13, 1980 at the Springfield Municipal Hospital. They have asked for a donation. This was granted by the committee. Mrs. Purdy also asked for an opinion on doing pap smears on women over 60 years of age. The committee voted against this.

The committee voted approval of the investment of $5,000 made through Merrill Lynch by Dr. Remsberg.

The budget for the year 1980-1981 was presented by Dr. Remsberg, Treasurer. The committee voted to accept the budget and the increase in dues to $115 per year.

A lengthy letter sent to Dr. Stoddard from a member will be mailed out to the Committee and discussed at the April meeting.

The meeting was adjourned at 9:50 P.M. □

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# EXECUTIVE COMMITTEE

The Executive Committee of the Hampden District Medical Society met on Tuesday, April 15, 1980 in the Conference Room.

Present were Drs. Navazio, Flahive, Walthall, Remsberg, Bagamary, Stoddard, Zadworny , Dasco and Mrs. Purdy. Dr. Morgan, representative from the Valley District Dental Society was present also.

CORRESPONDENCE

Two members who are delinquent paying dues to the Massachusetts Medical Society will be contacted by the Chairman of the Membership Committee.

A letter from Dr. Frechette, Commissioner of Public Health for Massachusetts was read. This letter was in answer to the letter of support sent to Dr. Frechette by Dr. Navazio for the Western Massachusettts Health Planning Council. Dr. Stoler, who serves on the Board Plan Development Committee of WMHPC, sent a resignation into that office if Mr. Joseph Roche was to still be employed by them to rewrite the Annual Implementation Plan which was rejected by HEW. Mr. Hooven Director replied to Dr. Stoler that Mr. Roche would be rewriting the plan with full support from the Board Plan Development Committee. After much discussion it was voted that Dr. Siragusa, President Elect of HDMS appoint a new physician to serve on that committee.

An informational exchange of correspondence between the Massachusetts Medical Society and a member physician interested in serving on the Continuing Education Committee was read. No action was taken.

Two delinquent members of Hampden District Medical Society recently indicated that they wanted to be reinstated in the Massachusetts Medical Society. Letters were sent to them from Dr. Shedd, Treasurer with the amount that they owed and indicated they would be reinstated when the back dues were paid.

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An announcement from Mayor DiMauro's office was read which stated that a new Office for Handicapped Affairs in Springfield has been opened. The committee asked that this be written in the Hampden Hippocrat for information to the members. A letter to this effect will be written to that office.

A letter from the American Academy of Pediatrics complementing the Hampden Hippocrat for the February issue which was in tribute to the 50th anniversary of the Academy was read.

OLD BUSINESS

No action was taken on a problem between several member physicians because a letter requested of one of the parties has not been answered.

Mrs. Purdy gave a report of the Worcester District Medical Society's invitation to 262 interns and residents in that county to attend a dinner meeting given expressly for them. Only 10% of the invited attended the dinner. No discussion followed.

Nominees for the Public Health Council who were suggested to Mayor DiMauro were not accepted by the Mayor's office. One physician should be appointed and he must be a resident of Springfield. Dr. Navazio has appointed Dr. Lewis Whiting and his name was approved by the Executive Committee.

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The Greater Springfield Health Planning Corporation (HMO) wrote indicating that the feasibility study is finished and they would like to discuss the results of the study and future plans. No action was taken at this time. (A letter signed by Dr. Navazio was sent.)

NEW BUSINESS

The Executive Committee approved all the Annual Reports as written in the April issue of the Hampden Hippocrat.

Dr. Siragusa wants to appoint one Hampden District Auxiliary member to attend committee meetings without a vote. This was approved by the committee.

Dr. Simpson resigned from the Publication Committee. The Publications Committee suggested the name of Dr. John Turner and this was approved by the committee.

Dr. LaMarche's letter regarding C.I.M. will be acted upon at the May meeting when Dr. Siragusa returns.

The request of the Academy of Medicine to hold CME meetings just prior to same dates as the District Meetings was postponed until May as Dr. Siragusa was on vacation at this time.

It was agreed to ask each person at the Annual Meeting for $1.00 to support the Hampden Hippocrat.

Dr. Tapp sent a note asking the Hampden District Medical Society to take action on a full page ad which appeared in the Springfield Union on April 9, 1980 regarding dieting. Mrs. Purdy will ask for an opinion from the AMA.

The meeting was adjourned at 9:45 P.M. □


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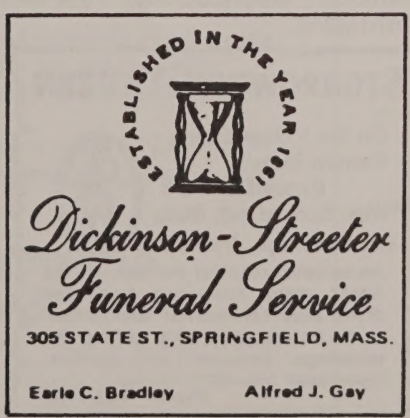
# Recent Trends In Child Neurology

At the time of the celebration of the fiftieth anniversary of the American Academy of Pediatrics, it would be appropriate to reflect upon the recent advances that have been made in the evaluation and treatment of children with a variety of neurologic disorders, particularly epilepsy.

Our understanding of the pathophysiology of epilepsy has been enhanced recently by a number of studies.Depth-electrode studies have enabled the investigator to determine that there are often subcortical epileptogenic discharges from the amygdala or hippocampus, for example, without any alteration in the scalp EEG. It has also been possible to determine more accurately the location of epileptogenic foci. This important information is needed before ablative neurosurgery can be considered for intractable epilepsy. New animal models of epilepsy have been discovered, such as the photosensitive baboon from Senegal, **Papio papio.** Other animals, especially cats and monkeys, have been subjected to daily, brief electrical stimulation of limbic structures in the brain with a resultant "kindling" of an epileptogenic focus with subsequent development of a variety of focal seizure types. This has enabled workers to trace the pathways of the generation of facal to generalized seizures as well as to draw analogies with the learning process where transfer of information transsynaptically is also involved.

These models are being utilized to test new anticonvulsants, which leads us to another major advance - new classes of anti-convulsants. Both Tegretol (carbamazepine( and Depakene (valproic acid) have been introducd for use in this country in the past five years. Tegretol, structurally related to the phenothiazines, is particularly useful in the treatment of seizures of focal onset such as psychomotor, or complex partial seizures. Depakene, a fatty acid, on the other hand, represents an entirely new class. It is useful in the treatment of absence seizures (petit mal) and the other primary generalized epilepsies such as grand mal and myoclonic seizures.

Not only have these two very new anticonvulsant drugs helped us immeasurably in caring for epileptic patients, but the institution of drug levels has been of at least as great an adjunct to effective treatment. If the patient appears clinically to be drug toxic on two or more



anticonvulsants, it can now quickly and easily be determined which is the offending drug. This information is available often in 24 hours at fairly low cost because of improvements in biomedical technology, particularly gas-liquid chromatography. In addition, now that we know the therapeutic ranges of these drugs, dosages are easily adjusted for the given seizure patient's own rate of metabolism.

Besides epilepsy, many advances have and are continuing to be made in neonatal neurology. With improved technology, neonatalogists are able to keep smaller and smaller premature infants alive, most with few neurologic sequelae. Although the clinical neurologic examination of these infants has improved somewhat, the introduction of the computerized tomographic brain scanner (CT-scan) has enabled us to correlate our clinical findings much more accurately with the actual visual localization of the intracranial lesion. This has greatly improved our understanding of the nature of such proceses as intraventricular hemorrhage. This entity was found in one study to occur in approximately 50% of all infants weighting under 1500 grams at birth. The follow-up evaluation of neonates and older children for hydrocephalus has been made very much easier with the CT-scanner. Only rarely do we need to do ventriculography or pneumoencephalography. Hospital admission can therefore often be obviated. The concern as with most new and expensive high technology in medicine is that it not be over-used or supplant the clinican's own diagnostic acumen or lend a false sense of security if the study is normal.

Other areas in which advances have been made include neuro-chemistry and genetics. Many new inborn errors of metabolism have been defined in the past decade. A few examples include the organic acidurias, e.g., methylmalonic and propionic acidurias, and the urea cycle disorders, e.g., ornithine transcarbamylase deficiency and carbamyl phosphate synthetase deficiency. A whole new realm of neurologic biochemistry has been entered with the ability to analyze the pyruvate dehydrogenase enzyme complex. Defects in various portions of this intricate series of biochemical reactions may explain at least a part of the neurologic and/or chemical findings in some of the spinocerebellar degenerative diseases and the congenital lactic acidoses. New and refined banding techniques for chromosomal analysis have identified a number of abnormal karyotypes - the deletions, duplications, translocations - previously not easily identifiable.

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In the area of Reye's syndrome survival has improved with attention to intensive supportive care and to proper use of various measures to lower increased intracranial pressure that develops because of the cerebral edema that is an integral part of the pathophysiology of this disorder. Exchange transfusions and peritoneal dialysis have fallen out of favor in the treatment of this disorder.

Muscle disorders have continued to receive much attention, too, in child neurology. Myasthenia gravis has been linked recently to the production of a circulating immunoglobulin that binds to the muscle endplate receptor, thus impairing neuromuscular transmission and therefore function. Thymectomy and plasmapheresis have been used to treat these patients, with a high percentage of cure with the former procedure and improvement with the latter. Better carrier identification techniques have been developed in Duchenne's muscular systrophy for genetic counseling purposes. Myotonic dystrophy has been appreciated more as a generalized membrane disorder with enzymatic and biophysical defects having been identified in erythrocyte membranes. Research a long these lines may eventually explain the increased association of multiple endocrinopathies and cardiac rhythm disturances in this disorder.

This brief overview of recent trends in child neurology has touched upon only a small number of the many significant advances. The last frontier in medical research - the developing human brain - is slowly being explored with the greatest discoveries yet to come. □

**ANTHONY H. JACKSON, M.D.**
**Pediatric Neurologist**

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# *CHILD ABUSE*

Abuse and neglect of children is a serious and pervasive problem in our society and is, therefore, encountered by every practitioner dealing with children on a regular basis. Physicians Caffey, Kempe, and Silverman were instrumental in stimulating interest and awareness of what is now known as a universal phenomenon. Physicians are currently losing their leadership either due to lack of education or interest as well as practical, legal, and economic concerns.

A historical perspective of abuse and neglect helps to better understand the problem and approaches to its management. This is by means a new problem. Infanticide, practiced by humanity since the beginning of recorded memory has probably been responsible for more childhood mortality than any other single cause.

Infanticide differs from the abuse seen today, it was approved by the culture often for religious or prophetic reasons, it was planned trauma so as to cause death, and it was practiced on an individual or a collectivce basis. Rationalization thus transferred responsiblity to a higher authority or institution.

Urbanization and industrialization brought on a new era and new types of abuse. With industrialization, children were exploited in large numbers for profit. Injury was no longer to newborns, as children over five years were primarily effected. The "Dickens" remains a euphemism in our literature for the beating of children. During this era, children over five were expected to work sixteen hour days and might be chained to work areas by their ankles to keep them from running away. In the 1890's there are reports of children who were murdered for the purpose of obtaining burial money.

Of course society now defines the abused and neglected child quite differently and, often, quite vaguely. For that reason, it is hard to arrive at a true incidence. In 1969, there were less than 10,000 reported cases, nation wide, of child abuse.

At the same time in New York City, which then had a reporting law, 2,600 cases were reported. Of these, less than a dozen were reported by private physicians. These figures are considered to be a serious underestimate of the true incidence of the problem.

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The definition of child abuse has undergone great changes since Henry Kempe first used and defined the term "the battered child syndrome", at the annual meeting of the Academy of Pediatrics, in 1962. This eye catching term is no longer considered broad enough to cover the whole spectrum of disease. Kempe defined children who had injuries inflicted on them by a care-giver. Fontanna enlarged the criteria with the term "Maltreatment Syndrome". In his definition, he incudes all children who have been neglected. A more contemporary definition of this syndrome has been given to us by Gil, who suggests that abuse and neglect is any force which compromises a child's capacity to achieve his full potential. This is not a well accepted definition, at present, but with the development of the "childrens rights" movement it may become a realistic definition.

With current definitions and reporting laws, the incidence changes greatly. In Massachusetts, where only 256 cases of child abuse were reported in 1972, there will be 5,000 cases reported in **Region 1** (Western Massachusetts) in 1979. Nationwide, the reports will be in the millions. The number of reported deaths from abuse per year in the United States is variously reported as between 700 and 5,000 per year.

There are laws covering the reporting of the child abuse in every state and protectorate in the United States. In addition, 43 of our 54 states and protectorates have laws requiring the reporting of neglect as well. These laws basically define mandated reporters (doctors, nurses, residents, teachers, social workers, policemen, etc.) as people who, under penalty of law, must report **suspected** cases of child abuse. In addition to creating a group of people mandated to report, the laws protect the reporter from any retribution or legal action as long as the the report is made in good faith. Recently Massachusetts has enacted a $1,000 penalty for mandated reporters who fail to report appropriate cases. In addition, in a 1976 California Supreme Court Ruling, the rights of foster parents to sue a doctor and hospital for subsequent injuries when a case was not reported, was upheld by the court.

As in any other area in medicine, diagnosis depends upon multiple factors. In addition to any physicial findings, the presentation, home environment, social factors, and family dynamics are all important pieces of information. Many professionals are left with a vague, uncomfortable feeling when this diagnosis is considered. They are more comfortable making orgainic diagnoses because they have laboratory work, cardiograms, or x-rays to confirm their diagnostic conclusions. However, with an adequate history, an appropriate physicial examination and good supportive services, one can, on firm ground, make a positive diagnosis of child abuse. All diagnoses of child abuse need not be made as diagnoses of exclusion.

Diagnosis ultimately implies recognition, which requires an awareness of the problem,acceptance as an entity,and information about it's incidence. The ability to diagnose accurately is also dependent on a command of social skills, and interviewing abilities, in addition to a comprehensive classical medical evaluation. A detailed medical, social, and family history as well as an analysis of provider/ interaction is necessary. The patient who presents with multiple emergency room or provider visits and differing stories regarding the same injury must be looked at with suspicion, particularly if the injury is not compatible with the child's age or history. Of particular concern, are those who present late with inconsistent, vague stories and inappropriate concerns.

Physical findings can vary from failure to thrive and poor skin and dental care to a number of types of soft tissue and skeletal injury. Most obvious may be injuries to soft tissue. The area of injury may show imprinting with the object which has inflicted the injury, such as a hand, a cigarette, or multiple other objects. Noteable also are bruises that are circumferential in nature and which can be dated as having occured at different times due to color or state of resolution. Injuries to the skeletal system may include dislocations, multiple long bone, rib, or skull fractures. These, while not diagnostic by themselves, may prove invaluable in combination with other information in making the diagnosis.

Of particular concern are fractures which are in variable stages of healing which can be well documented radiographically. Other inflicted injuries include sub-dural hematomas, retinal hemorrhage, and various abdominal injuries, among them lacerations or hematomas of the liver and spleen or ruptured and lacerated viscera.

Sexual abuse, frequently incest, is also much more common than literature suggests and is certainly more frequent than most people believe. The sexually abused child may present with multiple or vague constitutional symptoms, of complaints may be directed more specifically to the genito-urinary tract. High risk diagnoses include vaginits, gonorrhea, enuresis, and urinary tract infection. Presentation ofen occurs at particulary stressful times when intervention is consciously or subconsciously desired.

Societies view of children and their rights is constantly changing, as are it's expectations of the physician's role. Children are individuals rather than their parent's chattels and are entitled to certain rights and expectations that must be respected and, at times, protected. The abused or neglected child encountering a physician in his first interaction with society has the right to expect intervention in his behalf on the part of the doctor. It is imperative that medical schools and continuing education provide the tools (social, developmental, psychological, and medical) that create awareness and permit recognition and diagnosis of this condition. The physician must feel as comfortable with this diagnosis as with other more concrete disorders.

**EDWARD N. BAILEY, M.D.**

# *The Communication Gap*

Remember when **Hippie** meant big in the hips?
And a **Trip** involved travel, by cars, planes or ships?
And **Soul** was man's spirit, one heard of at church?
And **Action** was movement, a start, or a lurch?

When **Pot** was a vessel for cooking things in?
And **Hooked** was what Grandmother's rug might have been?
And **Neat** meant well-organized, tidy and clean?
And **Grass** was a ground cover, normally green?

When **Light,** and not people were turned on and off?
And the **Pill** might have been what you took for a cough?
And **Groovy** meant furrowed with ridges and hollows?
And **Birds** were winged creatures, like robins and swallows?

When **Fuzz** was substance, fluffy, like lint?
And **Bread** came from bakeries, and not from the mint?
And **Square** meant a 90 degree angled form?
And **Cool** was a temperature, not quite warm?

When **Roll** was a bun, and **Rock** was a stone?
And **Hang-up** was something you did to a phone?
When **Swinger** was someone who swung in a swing?
And a **Pad** was a soft, sort of cushiony thing?

And **Way-Out** meant distant and far, far away?
And **Cat** meant a feline, a pet, or a stray?
And **Dig** meant to shovel or spade in the dirt?
And **Put-On** was what you did to a shirt?

And **Tough** described meat too unyielding to chew?
And **Making a Scene** was a rude thing to do?
Words once so sensible, sober, and serious
Have now **Freaked Out, Man,** like they're Psyco-Delirous...

**Anon**

# *The Four Seasons*

Antonio Vivaldi, an obscure priest, in
the seventeenth century,
Composed some of the finest musical compositions
of all times.
The giants that followed him, Bach and
Beethoven, mimicked his musical form,
almost exclusively,
We discover new ideas, only be standing
upon the shoulders of others and improve
their styles.
Vivaldi wrote a violin concerto - entitled
Four Seasons;
Spring, Summer, Autumn and Winter
The beauty of each theme, musically expressed,
is a gem in all of tonal compositions.
It reminds me of our own life-span, the
intricate time-piece, that does not falter.
Spring, the span from birth to tribulations;
Summer, the interlude of youth, passion and vigor.
Autumn, an oasis, to harvest upon our needs and
hitherto attainment;
The Winter of our life, a period of reflection, what was,
what is, and what we now are.
Be not sad, for if you have but touched a single
soul and healed a festered wound.
you have done much, be content..

**SETRAG A. ZACARIAN, M.D.**

# LETTER TO THE EDITOR

Having recently reviewed a letter from Peter Hiam, Chairman of the Commonwealth of Massachusetts Rate Setting Commission, to one of our local legislators; I feel moved to write once again urging strongly that individual physicians not sign contracts with the Department of Public Welfare to provide services to Medicaid clients. Mr. Hiam in a letter dated January 9, 1980 made it clear that he considers the recent seven (7) percent increase in physicians fees to be fair reasonable and adequate. Mr. Hiam compares our first raise in many years with the six (6) percent given to AFDC recipients this year, and the four (4) percent cap on local expenditures passed this year. He does not, however, mention cost of living and local expenditure increases made over the past four years. He also chooses not to mention the fact that the rate setting commission does not even meet on a yearly schedule, as is mandated in federal regulations. As most of us know we cannot even bill for the increased fees because the new schedule will not be available till April. Computing interest at eighteen (18) percent and figuring a one month loss of availability of funds, the fee increase for the first year is decreased from seven to five and half (5½) percent. One can be sure that the Rate Setting Commission will point out that this is not their doing and that the DPW will claim that they will not help their action. The effect is that we lose a good portion of our paltry raise, and the Rate Setting Commission will not even acknowledge the fact.

The most interesting statement made by Mr. Hiam is that no crisis in the number of participating physicians yet exists. Implicit in this statement is the intimation that crisis politics and brinkmanship are the name of the game. I suggest strongly that we respond in kind. If none of us sign a contrat until reasonable changes are made I feel that the DPW will pay attention in short order. To continue with the shabby relationship which we have been sujected to over the past ten or twelve years will be an exercise in futility. □

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